Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN444AGC	A. BUILDING _____ B. WING _____	09/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING HEIGHTS	2397 EMPIRE RANCH ROAD CARSON CITY, NV 89701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual licensure survey - complaint investigation conducted in your facility on 9/21/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was seven. Seven resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received an annual licensure survey grade of A. The following deficiencies were identified:	Y 000		
Y 026 SS=D	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by:	Y 026		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 026	Continued From page 1 Based on observation and interview on 9/21/10, the facility was caring for 1 of 7 residents who required the assistance of at least one person to transfer or move from an unsafe area to an area of safety (Resident #1). Findings include: The facility is currently licensed for Category I residents. The facility failed to obtain an endorsement to admit or retain a Category II resident. Severity: 2 Scope: 1	Y 026		